STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 123089-001**

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 4th day of January 2012
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On August 25, 2011, attorney XXXXXX, authorized representative of XXXXX (the Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On September 1, 2011, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

The Petitioner receives health care benefits under a certificate of coverage issued by Blue Cross Blue Shield of Michigan (BCBSM). The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on September 2, 2011.

The issue in this external review can be decided by a contractual analysis. The contract here is BCBSM's *Community Blue Group Benefits Certificate* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On February 15, 2011, the Petitioner, then X years old, was taken by his mother to an urgent care center in XXXXX, XXXXX where it was determined that his symptoms were consistent with acute appendicitis. The urgent care center staff advised Petitioner's mother to

immediately take him to the emergency room at nearby XXXXX Medical Center. The XXXXX staff diagnosed Petitioner with a perforated appendix and intra-abdominal abscess. Vassar did not have a surgeon capable of treating Petitioner's condition so he was transported by ambulance to XXXXX Medical Center. The Petitioner had emergency surgery at XXXXX and remained there from February 16 through February 24, 2011.

XXXXX Medical Center is Blue Cross Blue Shield (BCBS) participating provider. BCBSM paid claims for the XXXXX services at BCBSM's normal rate. Because XXXXX a participating provider, the Petitioner's family was not required to make any additional payment to Vassar.

The ambulance service that transported Petitioner was not a BCBS participating provider. The Petitioner's parents paid a deductible for the ambulance service and BCBSM paid its approved amount. The Petitioner's parents have not appealed the amount of the payment to the ambulance service.

However, XXXXX Medical Center is not a BCBS participating provider. XXXXX charged $65,020.35 for its care to Petitioner. BCBSM paid its approved amount of $23,264.36, leaving Petitioner's family with a balance of $41,755.99.

Petitioner's parents appealed BCBSM's payment to XXXXX through BCBSM's internal grievance process, asserting that BCBSM's payment to XXXXX was inadequate. BCBSM held a managerial-level conference on May 27, 2011, and issued its final adverse determination dated June 21, 2011.

III. ISSUE

Is BCBSM required to pay an additional amount for the care Petitioner received from XXXXX Medical Center February 16 through February 24, 2011?

IV. ANALYSIS

BCBSM's Argument

In its final adverse determination of June 21, 2011, BCBSM denied additional reimbursement for Petitioner's care at XXXXX stating:

> Our approved amount for the emergency services provided is $23,264.36. Payment was previously issued to the provider. Because the provider has not signed an agreement with its local plan to accept our payment as full reimbursement, the provider may bill you for the difference between its charged amount and Blue Cross Blue Shield's approved amount. The remaining balance is an issue between you and the provider.

Petitioner's Argument

The Petitioner's representative requests that the Commissioner order BCBSM to pay XXXXX Medical Center the full amount XXXXX charged for its care. In a letter dated August 20, 2011, Petitioner's representative wrote:

> We are appealing a denial of coverage by Blue Cross Blue Shield of Michigan . . . for the Emergency Hospitalization of XXXXX . . . at XXXXX Medical Center . . . during the period of 2/16/11 – 2/24/11.
>
> * * *
>
> XXXXX Medical Center is an out of network provider for [BCBSM] however, the [BCBSM] policy clearly states, "Out of network hospital treatment for 'emergency services' are 100% covered after a $250 deductible per family member, and a $150 copay. Further, according to Section 44 of the NY Medical Health Code, Insurers must cover 100% of the charges for emergency services delivered by a qualified provider (i.e. a doctor) whether or not they are incurred out of network.

In addition, the Petitioner's representative argues that the medical records and opinions of the Petitioner's treating physicians demonstrate that all the Petitioner's medical care at XXXXX was emergency medical treatment. The representative further argues that that BCBSM is an HMO and must therefore comply with the requirements for emergency treatment imposed on HMOs under Michigan law.

Commissioner's Review

It is first necessary to correct several inaccuracies in the argument presented by the Petitioner's representative. BCBSM is not an HMO. Rather it is a nonprofit health care corporation created and regulated under Michigan's Nonprofit Health Care Corporation Reform Act, MCL 550.1101, *et seq.* Because the Petitioner's health benefits are provided under a contract issued in the state of Michigan, it is Michigan law that applies when reviewing claims determinations made by BCBSM. Whatever requirements may exist in XXXXX regarding health care law, they are not applicable to this review.

The Petitioner's representative has also asserted in her August 20 letter that the Petitioner's policy:

> clearly states, "Out of network hospital treatment for "emergency services" are 100% covered after a $250 deductible per family member and, a $150 copay. (See attached, Exhibit "B").

These assertions are not accurate. The document attached as Exhibit B is a summary of benefits which states that emergency medical care provided in an out-of-network hospital emergency room is "Covered - - $150 copay per visit (copay waived if admitted or for an accidental injury)." The document does not state that emergency care is "100% covered."

The certificate of coverage provides the following provision describing hospital emergency care:

> **Section 3: Coverage for Hospital, Facility and Alternatives to Hospital Care**
>
> *** * ***
>
> **HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID**
>
> *** * ***
>
> **Emergency Services at a Nonparticipating Hospital**
>
> We will pay our approved amount, less any member cost-sharing amounts, for emergency services provided by an **accredited nonparticipating hospital:**
>
> - Located outside of Michigan in an area not served by another Blue Cross and/or Blue shield Plan or
> - Participating with another Blue Cross and/or Blue Shield Plan, regardless of the facility's location.

For the purpose of this review, the Commissioner can accept the assertion of the Petitioner's representative that the care provided at XXXXX was emergency care. BCBSM processed the Petitioner's claims under the emergency treatment provisions of its *Community Blue* certificate of coverage.

The certificate does not guarantee that a provider's charge will be paid in full. Throughout the Community Blue certificate, BCBSM indicates it pays its "approved amount" for covered services. The certificate, on page 7.2, defines "approved amount" as:

> The lower of the billed charge or our maximum payment level for the covered service. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

BCBSM has paid its approved amount for Petitioner's care. The Commissioner finds that BCBSM correctly processed the claims.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of June 21, 2011, is upheld. BCBSM is not required to pay any additional amount for the Petitioner's February 16 through February 24, 2011, care received from XXXXX Medical Center.

This is a final decision of an administrative agency. Under MCL 550.1915(1), any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner